Amendments to the Claims:

The listing of claims will replace all prior versions and listings of claims in the application.

Listing of Claims

1. (canceled) A system for reviewing medical treatment claims provided by a plurality of practitioners to a plurality of insurance entities for the determination of the appropriateness of the medical treatment claims provided to a plurality of patients, comprising:

a clearing house for receiving information from the plurality of practitioners regarding claims to be paid by one or more of the plurality of insurance entities, said clearing house provided with software to determine the appropriateness of each of the claims submitted by each of the plurality of practitioners, wherein said software determines the appropriateness of each of the medical treatment claims based upon whether a single practitioner has submitted more than one disparate medical treatment claim for a single block of treatment time on a single day for different patients, said clearing house communicating with the plurality of insurance entities and the plurality of practitioners regarding the appropriateness of each of the claims.

2. (canceled) The system in accordance with claim 1, wherein said clearing house pays the proper practitioner once said clearing house has determined that a particular claim submitted by that practitioner to said clearing house is appropriate.

4. (canceled) The system in accordance with claim 1, wherein said software determines the appropriateness of each of the claims based upon the total number of claim hours submitted by one of the practitioners for a particular duration of time.

5. (canceled) The system in accordance with claim 4, wherein said particular duration of time is one work day.

6. (canceled) The system in accordance with claim 1, wherein said clearing house is provided with a memory containing a list of treatment codes and a list of diagnostic codes.

7. (canceled) The system in accordance with claim 6, wherein said clearing house determines the appropriateness of each claim based reviewing a treatment code with respect to a diagnostic code for a particular patient.

8. (canceled) The system in accordance with claim 6, wherein said clearing house determines the appropriateness of each claim based upon a determination that a plurality of said treatment codes are mutually exclusive.

9. (canceled) The system in accordance with claim 2, wherein said clearing house is paid by the appropriate insurance entity when said clearing house pays the proper practitioner.

10. (canceled) The system in accordance with claim 1, further including a device for entering data provided at each of the practitioner locations.

11. (canceled) The system in accordance with claim 10, wherein said device includes a bar code reader.

12. (canceled) The system in accordance with claim 10, wherein said device inclines a keyboard.

13. (canceled) A method of determining the appropriateness of a treatment claim submitted by one of a plurality of practitioners to one of a plurality of insurance entities, the claimed treatment claim covering a treatment prescribed to a patient based upon a particular diagnosis or condition, comprising the steps of:

establishing a clearing house for examining each of the treatment claims;

submitting treatment claims to said clearing house;

reviewing each of the treatment claims to determine the appropriateness of each of the treatment claims, said reviewing step including determining whether a single practitioner has submitted more than one disparate medical treatment claim for a single block of treatment time for different patients during a single day; and

communicating with the appropriate practitioner and the appropriate insurance entity the appropriateness of each of said treatment claims.

14. (canceled) The method in accordance with claim 13, including the step of having said clearing house pay the practitioner if said reviewing step indicates that a particular submitted treatment claim was appropriate.

15. (canceled) The method in accordance with claim 14, including the step of having one of the insurance entities pay said clearing house if said reviewing step indicates that a particular submitted treatment claim was appropriate.

17. (canceled) The method in accordance with claim 13, wherein said reviewing step determines the appropriateness of each treatment claim based upon the total number of claim hours submitted for an articular duration of time.

18. (canceled) The method in accordance with claim 17, wherein said duration of time is a work day.

19. (canceled) The method in accordance with claim 13, wherein said reviewing step includes comparing a treatment code included in said treatment claim with a diagnosis code included in said treatment claim.

20. (canceled) The method in accordance with claim 13, wherein said reviewing step includes comparing more than one treatment code included in said treatment claim with one another.

21. (canceled) The method in accordance with claim 13, further including the step of obtaining a pre-authorization from one of the insurance entities for the treatment covered by said treatment claim.

22. (new) An apparatus for making heath care insurance provider reimbursable payments to practitioners for claims submitted to health care insurance providers for a medical treatment provided to a patient, said apparatus comprising:

an electro-mechanical device for inputting medical treatment information to include the identity of the patient, the time of the medical treatment, the identity of the practitioner performing the medical treatment, a diagnostic code and a treatment code and transforming said medical treatment information into electrical signals;

means for transmitting said electrical signals to a computer, said computer having access to memory for storing a data base including diagnostic codes, treatment codes and heath care insurance provider treatment approvals;

said computer being programmed to block health care insurance provider reimbursable payments to practitioners for claims submitted to health care insurance providers for medical treatments under one or more of the following blocking conditions:

absence of medical treatment approval for the patient by a health care insurance provider;

medical treatment code is inconsistent with a diagnostic code;

multiple medical treatments performed a time period selected from a group including one or more of:

multiple medical treatments performed at the same time by an individual practitioner;

denial of other claims during the same time period by an individual practitioner for medical treatment; and

prior payment for medical treatments performed during the same time period by an individual practitioner;

mutually exclusive medical treatment codes;

said computer being programmed to make health care insurance provider reimbursable payments to practitioners in response to claims for medical treatments provided and request reimbursement for the claims from the health care insurance providers.

23. (new) The apparatus as defined in Claim 22 further including means for transmitting information from said computer to the health care insurance provider.

24. (new) A method for making health care provider reimbursable payments to practitioners for claims for medical treatments provided to patients, said method comprising the steps of:

inputting medical treatment information including the identity of the patient, the time of the medical treatment, the identity of the practitioner performing the medical treatment, a diagnostic code and a treatment code into an electro-mechanical device;

transforming said medical treatment information into electrical signals;

transmitting said electro-mechanical signals to a computer having access to a memory for storing a data base including diagnostic codes, treatment codes and health care insurance provider treatment approvals;

causing said computer to block health care insurance provider reimbursable payments to practitioners for claims submitted to health care insurance providers for medical treatments under one or more of the following conditions:

absence of medical treatment approval for the patient by a health care insurance provider;

medical treatment code is inconsistent with a diagnostic code;

multiple medical treatments performed during a time period selected from a group including one or more of:

multiple medical treatments performed at the same time by an individual practitioner;

denial of other claims for medical treatment during the same time period; and

prior payment for medical treatments performed during the same time period by an individual practitioner;

mutually exclusive medical treatment codes;

causing said computer to make health care insurance provider reimbursable payments to practitioners in response to claims for medical treatments provided and request reimbursement for the claims from the health care insurance providers.

25. (new) The method as defined in Claim 24 further including the step of transmitting information from said computer to the health care insurance provider.